

**AFFIDAVIT OF HEALTH CARE PROFESSIONAL PER SECTION 28-33-8(c) OF THE
RHODE ISLAND WORKERS' COMPENSATION ACT**

State of Rhode Island
Workers' Compensation Court
Medical Advisory Board
One Dorrance Plaza, Providence, RI 02903
Phone: 401-458-3460
TDD: 401-458-5275

EMPLOYEE INFORMATION:

Social Security No.: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

EMPLOYER INFORMATION:

FEIN: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION.

INSURANCE CARRIER:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

ADJUSTING COMPANY:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

EMPLOYEE'S INJURY INFORMATION:

Injury Date: _____

Incapacity Date: _____

PREPARED FOR THE WEEK AFTER EMPLOYEE'S DATE OF INJURY INDICATED BELOW

Six _____ Twelve _____ Eighteen _____ Other _____

SECTION 28-33-8(b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A \$20.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM WITHIN ONE WEEK OF THE DUE DATE.

Now comes the undersigned Physician and after first being duly sworn on oath makes affidavit and states:

1. The nature of the injury for which this employee is being treated is as follows:

Diagnosis: _____
Diagnosis: _____
Diagnosis: _____

ICD 9 Code: _____
ICD 9 Code: _____
ICD 9 Code: _____

2. The type of treatment provided to date, including frequency, is as follows:

Number of visits, to date: _____

Frequency of visits: _____

Type of treatment, including modalities: _____

3. Expected further treatment, including type, frequency, and duration of treatment(s) is as follows:

(If none, so state.)

Expected future number of visits: _____

Frequency of future visits: _____

Type of treatment, including modalities: _____

4. The employee's functional capabilities are as follows: (If none, so state.)

Health Care Provider's Signature: _____

Lic. # _____

Health Care Provider's Name: _____

Date: _____

Title: _____

Name of Facility: _____

Facility Address: _____

Subscribed and sworn to before me by the above-named health care provider this _____ day of _____, 20____.

Notary Public
My Commission Expires: _____